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No. 93-1735

In The

Supreme Court of the United States

October Term, 1993

CRAWFORD B. SMITH, JR. and JEANNIE SMITH,

Petitioners,

v.

JEFFERSON PILOT LIFE INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF IN OPPOSITION

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33 pp

QUESTIONS PRESENTED

The "Questions Presented" as stated by Petitioners are not properly presented. The only questions that *could* be presented, and Petitioners have chosen not to directly present them, are the following:

1. Did the Court of Appeals err in the reversal of the District Court, holding that a health plan sponsored by an insurance company for its agents, funded by the employer through an insurance policy that it issued to the Plan; and, including a dependent benefit feature conditioned upon payment of a monthly contribution to the plan, satisfied the prerequisites of ERISA Section 1002(1), qualified as an ERISA-governed welfare plan, and was not removed from ERISA's regulatory design by Plaintiff's interpretation of DOL Regulation 29 C.F.R. § 2510.3-1(e);

2. Did the Court of Appeals err in reversal of the District Court, holding that Petitioners' claim under O.C.G.A. § 33-24-44, as applied to administration of ERISA governed health benefits funded through a policy of insurance, was preempted as a law "relating to" an ERISA health plan; and was not saved from preemption because such law did not qualify as a law which regulates the business of insurance within the "savings clause" of ERISA Section 514(b), 29 U.S.C. § 1144(b).

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STATEMENT OF THE CASE

This Petition, fifty-six (56) pages in length, contains a section titled "summary of facts"; the allegations contained therein are certainly not the "facts" of this record. Petitioners' prolix "fact statement" is composed almost entirely of unproven allegations and argument. Petitioners' self-serving version of events has never been the subject of evidence; there have been no findings of fact in these proceedings. Petitioners' "summary of facts" is nothing but their compendium of allegations which are vigorously disputed.

And, Petitioners' allegations concerning the merits of their wrongful denial of benefits claim are not at all relevant to the instant Petition because, prior to any hearing on the merits of Petitioners' claim, the district court entertained cross-motions for summary judgment on two narrow, strictly legal issues: 1) whether the Company's group medical plan for agents and their eligible dependents (the "Medical Plan" or the "Plan") constituted an "employee welfare benefit plan" within Section 3(1) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1002(1); and, if the Plan did in fact fall within ERISA's regulatory scope, whether O.C.G.A. §33-24-44, invoked by Petitioners as the basis of their statutory and common law tort claim, is preempted by ERISA Section 514, 29 U.S.C. §1144. The sole relevant

facts of this case, which are of record and undisputed, are as follows.[1]

STATEMENT OF FACTS

At all times relevant, Petitioner Crawford Smith was employed by Jefferson Pilot Life Insurance Company[2] as a sales agent. The Company, in its capacity as employer, provided major medical benefits to agents through a "Group Life and Medical Insurance Plan for Agents and General Agents" (the "Plan"). The Company bore 100% of the costs of Plan medical benefits provided to agents. Petitioners have never contested the fact that the Plan fully satisfied the ERISA Section 3(1) definition of a "welfare benefit plan." 29 U.S.C. §1002(1).

Plan terms were contained in a summary plan description booklet ("SPD") published by the Company.

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[1] Petitioners' protracted "statement of facts" provides little, if any, information probative of the issues before the Court. The Company will not engage in a point-by-point refutation of Plaintiffs' discursive presentation; rather, it returns to governing legal precepts of ERISA application and preemption, which are not affected by Petitioners' self-serving version of "facts".

[2] Prior to 1987, Crawford Smith was employed by Pilot Life Insurance Company. Pilot Life merged with Jefferson Pilot in 1987. Reference to "the Company" or the Company's benefit Plan encompasses Defendant as well as its predecessor, Pilot Life. Petitioners Mr. and Mrs. Smith are referred to by name or collectively as "Petitioners". Respondent Jefferson Pilot Life Insurance Company is referred to as "Respondent" and "the Company". The Company is based in North Carolina and does business in forty-five (45) states. Its agents who participate in the Plan reside in states across the U.S.

The SPD detailed medical benefits and described claim procedures; it included a statement of ERISA rights and remedies. The SPD designated a Welfare Benefits Administration Committee as administrator of the Plan. It informed participants that medical benefits for agents were funded by the Company through group insurance Policy No. 3469 written by the Company to the Plan.

Further, the SPD described the Plan's dependent coverage feature. The Plan provided that eligible dependents could participate in the Plan, and be eligible for medical benefits provided through Policy No. 3469, by enrolling in the Plan and by the agent's payment of monthly contributions on the dependent's behalf. The SPD informed participants that where dependent coverage was elected, the required monthly contributions would be collected via deduction from the agents' commission account. It informed participants that if monthly contributions were not made, then dependent participation in the Plan would terminate. In 1981, Crawford Smith enrolled Mrs. Smith in the Plan under the dependent coverage feature.

In 1986, Plan administrators determined that Mrs. Smith's eligibility for Plan medical benefits was terminated due to Mr. Smith's failure to make the monthly contributions required as a condition precedent to dependent coverage. Mr. and Mrs. Smith disputed the Plan's determination that participation was terminated; they claimed that any failed payment was based on mutual mistake and/or the fault of the Plan and/or the Company. This benefit entitlement dispute became the subject of the instant lawsuit.

In their lawsuit, Petitioners have assiduously avoided making any claim under ERISA and ERISA's Section 502 remedial scheme. Rather, they have made various state law claims including alleged violation of Georgia statute O.C.G.A. §33-24-44, which imposes certain duties concerning notice in the cancellation of insurance policies. Petitioners have argued that this cancellation law governs the Plan, and that O.C.G.A. §33-24-44 notice requirements were not satisfied by Plan administrators when Mrs. Smith's Plan benefit eligibility terminated. Petitioners seek to hold the Company liable for violation of O.C.G.A. §33-24-44 and for tort liability allegedly related to the administrative failure to give notice.

Petitioners have never addressed the fact that the only insurance policy which had any relationship to the subject health benefits, Policy No. 3469, was never cancelled or suspended. There was never a "cancellation" of any policy of insurance within the meaning of O.C.G.A. §33-24-44. The events at issue in this litigation do not involve "cancellation" of any insurance policy; they involve administration of the Plan, and the Plan's termination of Mrs. Smith's eligibility for Plan benefits for failure to satisfy Plan conditions governing dependent coverage.

As noted, prior to any evidentiary hearing, the trial court entertained cross-motions for partial summary judgment on the questions of whether ERISA governed this cause and whether ERISA preempted application of O.C.G.A. §33-24-44 as relating to the administration and termination of the Plan. The district court first rejected ERISA application; and, alternatively held that O.C.G.A.

§33-24-44 as applied to Plan benefit termination, was saved from ERISA preemption as a law which regulates insurance. The Eleventh Circuit granted the Company's petition for interlocutory review of both rulings. After briefing and oral argument, the Eleventh Circuit reversed both holdings of the district court, confirming ERISA plan status and preemption.

The sole issues before the district court, and ultimately before the Eleventh Circuit, were (1) whether the health coverages afforded to Mrs. Smith as Mr. Smith's dependent through the Company Plan, constituted a welfare plan governed by ERISA; and, (2) whether O.C.G.A. §33-24-44, is preempted when applied to the administration of an ERISA governed welfare plan.

REASONS FOR DENYING THE WRIT

Contrary to the Petitioners' claims, this case does not present any conflict with prior decisions of this Court, nor have Petitioners shown that there is a conflict with any decision of another Court of Appeals on the same matter. Petitioners have not substantively identified any conflict, in principle or spirit, with the body of law governing the scope of ERISA preemption and/or the limits of the ERISA savings clause as set forth in Section 514 of the Act. The instant decision, which properly applies McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.*, indicia to determine whether the cancellation law constitutes a law which regulates the business of insurance, is entirely consistent with this Court's holdings and the decisions of sister Courts of Appeal. Section 514 of ERISA expressly

preempts state laws which "relate to" an employee benefit plan. *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). Georgia statute O.C.G.A. §33-24-44, which purports to regulate benefit eligibility and Plan administration, plainly relates to an ERISA plan. The Court of Appeals properly held that such regulation is plainly preempted by ERISA. There is no basis for further review.

The Court of Appeals properly reversed the district court's finding that DOL regulations at 29 C.F.R. §2510.3-1(e) exempt this Plan from ERISA because the dependent coverage provision required a contribution to qualify for health benefits funded by an insurance policy issued by the Company to the Plan. Petitioners concede that there are no conflicting decisions, in principle or otherwise, with the Court of Appeal's interpretation of 29 C.F.R. §2510.3-1(e). There has never been any case which supports Petitioners' novel construction of this Regulation; their strained interpretation would effectively destroy ERISA coverage to all insurance industry employees who are participants in plans funded through policies of insurance issued by the insurer-employer to the plan. Petitioners have grasped at straws to avoid ERISA. There is no basis for this Court's further review.

Contrary to the apocalyptic language and prolix claims asserted in the Petition for Certiorari, the two issues presented to the Eleventh Circuit in this case were narrow and precise. The Court of Appeals reversed the decision of the district court granting partial summary judgment because the district court misconstrued ERISA's

preemption and savings clause, 29 U.S.C. §1144, and misapplied Department of Labor regulations at 29 C.F.R. §2510.3-1(e). The district court failed to consider that the Company health program for agents, funded via a group insurance policy written by the Company to the Plan, was clearly within the definition of an ERISA governed plan; and the dependent coverage feature, which provided coverage conditioned upon a payment to the Plan, would not abrogate ERISA regulation.

The district court further failed to appreciate that Petitioners' claims, although couched in terms of Georgia state law, are in fact grounded on their dispute with Plan administrators concerning benefit eligibility and entitlement. The remedy for alleged wrongful denial of ERISA benefits, which is plainly the crux of this lawsuit, is governed by ERISA's exclusive remedial scheme. 29 U.S.C. §1132. The Court of Appeals correctly so held.

> The *Pilot Life* court made clear that §1132 is a comprehensive scheme for enforcement of ERISA plan disputes, adding that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." 481 U.S. at 54. The claim at issue in *Pilot Life* sought to recover benefits due under the plan pursuant to §1132(a)(1)(B). *The instant case concerns a claim that the defendant wrongfully lapsed coverage; thus, it involves a suit to enforce the plaintiff's rights under the plan, which is covered under §1132(a)(1)(B).*

Appendix, page 31 n.12 (emphasis supplied).

The Court of Appeals held that the health coverages allegedly due to Mrs. Smith were provided pursuant to an ERISA governed health plan. The Court of Appeals confirmed that Petitioners clearly had a remedy for such alleged wrongful denial – the parameters of such remedy was governed by the remedial scheme set forth at ERISA Section 502, 29 U.S.C. §1132.

The arguments set forth in this Petition, like the arguments to the Court of Appeals, reflect Petitioners' efforts to avoid the ERISA remedies which were and continue to be entirely available. The Court of Appeals correctly held that, Petitioners' claims grounded on O.C.G.A. §33-24-44 and state tort law are preempted. The Court properly remanded this cause for further proceedings under the parameters of ERISA.

I. The Court Of Appeals Did Not Depart From Settled Law Or Conflict With Other Courts Of Appeal In Reversing Partial Summary Judgment And Remanding This Cause For Further Proceedings.

The Court of Appeals determination, that O.C.G.A. §33-24-44, and any tort claim thereunder is preempted by ERISA and not saved from preemption as a "law which regulates insurance", is firmly grounded in the language of the statute, and the decisions of this Court, and numerous, unanimous Courts of Appeal decisions. *See, e.g., Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 482, 112 L.Ed.2d 474, 483 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987); *Willett v. Blue Cross and Blue Shield of Alabama*, 953 F.2d 1335 (11th Cir. 1992); *Hansen v. Continental Ins. Co.*,

940 F.2d 971, 979 (5th Cir. 1991); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 493-94 (9th Cir. 1988). The instant Petition contains nothing more than a restatement of Petitioners' argument to the Court of Appeals and their insistent disagreement with the Court of Appeals' determination. As shown below, their efforts to identify some "conflict" between the Court of Appeals decision and Supreme Court and/or sister circuit precedents is a distinct failure.

A. The Court Of Appeals Decision Concerning ERISA Preemption Of Petitioners' State Law Claims Is Grounded On Established And Unanimous Authorities; Petitioners' Views Concerning the McCarran-Ferguson Test, As Applied To This ERISA Preemption Question, Are No Basis For Supreme Court Review.

Petitioners' first argument concerns ERISA preemption of O.C.G.A. §33-24-44 as applied to the administration of ERISA governed health benefits funded by insurance. Petitioners argue that the Court of Appeals decision "conflicts with the decisions of at least two other United States Courts of Appeal", and "has misinterpreted the risk-spreading principle as it is generally understood". Petition, pp. 21, 24. Petitioners' arguments misstate the law and provide no basis for Supreme Court review.

The Court of Appeals properly relied on this Court's clear directive that, in construing ERISA's Section 514(b) savings clause, McCarran-Ferguson criteria are utilized to determine whether a state law is directed at the "business of insurance" so as to "escape preemption by operation of

the ERISA savings clause." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985); *see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 41. The crux of Petitioners' disagreement with the Court of Appeals focuses on two McCarran-Ferguson criteria, i.e., the question of whether the subject state law regulates "transfer of risk"; and whether the statute affects an "integral part of the relationship between the insurer and the insured". In fact, the Court of Appeals carefully and correctly considered both of these McCarran-Ferguson criteria in its preemption analysis.

The Court of Appeals' consideration of risk spreading, as applied to O.C.G.A. §33-24-44, was in full accord with this Court's analysis in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 130, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982). Citing *Pireno*, the Court of Appeals held that the transfer of risk is completed at the time the contract is entered. Appendix, pp. 24-25. Thus, in full accord with *Pireno*, the apportionment of risk in the instant case (i.e., what medical coverages were to be provided to the group of Plan participants eligible for Plan benefits), was determined at the time that Policy No. 3469 was issued. Neither Mrs. Smith's eligibility for Plan benefits, nor her termination of eligibility, had any effect on the apportionment of risk under this Court's *Pireno* analysis. Petitioners have identified no conflict whatsoever between this Court of Appeals decision and *Pireno*.

On the "transfer of risk" question, the record fact is that Petitioners never purchased and were never issued any policy of insurance by the Company; there was never any risk spread between Petitioners and the Company;

the only policy in question was issued to the Plan. Petitioners' argument, that the "transfer of risk" is governed by O.C.G.A. §33-24-44 (which merely sets notice standards for policy cancellation), was fully argued to and rejected by the Court of Appeals. There is no basis for any further review.

> [A]lthough a statute that prevents cancellation of a policy without notice arguably affects the transfer of risk, since it regulates the conditions under which the insurer must continue to bear risks for the insured, it does not alter the initial apportionment of risk among the parties at the inception of the contract. The first prong of the business of insurance test concerns only laws that impact the original apportionment of risks covered by the policy. The statute before us merely attempts to minimize the risk of noncoverage to persons whose policies lapse. *See, Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 109 (5th Cir. 1993). . . .

Appendix, p. 25 n.9.

Petitioners cite *Ticor Title Ins. Co. v. Federal Trade Commission*, 998 F.2d 1129, 1134 (3rd Cir. 1993) and *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449, 1454 (5th Cir. 1991) and claim that these two decisions conflict with the Eleventh Circuit's "transfer of risk" analysis.

Petitioners simply refuse to appreciate the fact that *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449 (5th Cir. 1991) has absolutely no application to the instant facts. The Louisiana statute in *Gahn* which was deemed an insurance regulation for purposes of the ERISA savings clause, is not comparable to O.C.G.A. §33-24-44. The Louisiana

statute does not provide "notice" requirements for cancellation. The Louisiana statute does not deal at all with administrative notice requirements. Rather, the Louisiana statute mandates that medical coverage for certain pre-existing health conditions must continue irrespective of policy cancellation. Here, the Court of Appeals specifically considered and rejected Petitioners' reliance on *Gahn*, correctly noting the substantive difference between the Louisiana mandated insurance benefit law, and O.C.G.A. §33-24-44 administrative notice requirements:

> The Plaintiff relies on *Gahn v. Allstate Life Ins. Co.* to support his argument that the statute affects an integral part of the policy relationship. 926 F.2d 1449 (5th Cir. 1991). . . . [The Louisiana statute] mandated the continued payment of benefits after cancellation to certain policy holders. O.C.G.A. §33-24-44(d) does not affect the terms of coverage. It regulates the procedure for ending the policy relationship, and adds to the administrative requirements that group policies face.

Appendix, p. 28 n.10.

In *Willett v. Blue Cross and Blue Shield of Alabama*, 953 F.2d 1335, 1341 n.6 (11th Cir. 1992) and in the instant decision, the Court of Appeals found that a state statute imposing cancellation notice requirements is administrative; such statute does not qualify as a law which regulates the business of insurance. No "risk is spread" by virtue of a statute which provides a purely administrative notice requirement. The *Willett* decision is conspicuously absent from Petitioners' Brief to this Court.

Petitioners' citation to *Ticor Title Insurance Company v. Federal Trade Commission*, 998 F.2d 1129, 1134 (3d Cir. 1993) adds nothing to their misapplication of *Gahn*, and their contention that the Court of Appeals' analysis of O.C.G.A. §33-24-44 is wrong. *Ticor* does no more than make cursory reference to and reject *Gahn* as inapplicable to the *Ticor* facts.[3] Whatever cursory language the *Ticor* court utilized to summarize *Gahn*, the fact is that *Gahn* dealt with a Louisiana statute mandating continuing insurance coverage as to all existing claims; such is entirely different from O.C.G.A. §33-24-44 which deals only with administrative notice of cancellation; and which is not a law which regulates insurance for purpose of the ERISA savings clause. *Willett*, 935 F.2d at 1341. The Court of Appeals analysis is not in conflict with *Ticor* or *Gahn* or any other Circuit Court decision. There is no basis for this Court's further review.

Petitioners next contend that the Court of Appeals wrongly held that O.C.G.A. §33-24-44 does not impact an integral part of the policy relationship between the

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[3] In fact, the *Ticor* description of the *Gahn* holding is incorrect. In *Ticor*, the Third Circuit described Louisiana state statute at issue in *Gahn*, as "establish[ing] certain conditions precedent to an insurers power to cancel a pre-existing insurance contract". In fact, the Louisiana statute at issue in *Gahn* has nothing to do with "conditions precedent to cancellation"; rather, it effectively prohibits cancellation and mandates continuous coverage as to certain "benefits accrued". 926 F.2d at 1449. Petitioners cannot successfully exploit the *Ticor* misstatement for the proposition that notice/cancellations laws such as O.C.G.A. §33-24-44 must be saved from preemption under the authority of *Gahn*. The Louisiana statute in *Gahn* had nothing to do with "notice of cancellation" that is the subject of O.C.G.A. §33-24-44.

insurer and the insured. The Court of Appeals specifically considered and rejected the Petitioners' continued reliance on *Gahn v. Allstate Life Ins., supra.* The Court of Appeals correctly concluded that a statute which imposes administrative notice requirements incident to cancellation is not comparable to a law mandating benefits. Appendix, p. 28 n.10. Petitioners' citation to the Louisiana statute considered in *Gahn* provides no legitimate support for their claim that O.C.G.A. §33-24-44 must be deemed a law which regulates the "business of insurance". As applied to an insurance funded welfare Plan, such purports to regulate Plan administration, and particularly the administration of ERISA benefit termination. Such state regulation of Plan administration is clearly preempted by ERISA Section 514, and the Court of Appeals correctly so held.

The Court of Appeals correctly analyzed and applied the body of law developed under ERISA which confirms that plan administration is a central ERISA concern; ERISA is designed to provide uniformity in the administration of benefit plans for the protection of all participants. *FMC Corp. v. Holliday,* 498 U.S. 52, 59-60, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990); *Fort Halifax Packing Co., Inc. v. Coyne,* 482 U.S. 1, 9, 107 S.Ct. 2211, 961 L.Ed.2d 1 (1987); *Pilot Life,* 481 U.S. at 46. Uniformity and administrative consistency would be discarded if ERISA plans were subject to administrative cancellation laws of every state in which plan participants reside; rights and obligations would vary according to the state in which the participant happens to live. Such is in stark contrast to this Court's ERISA analysis and the uniform and consistent

administration of welfare plans that ERISA is designed to achieve. *Id.*

The Court of Appeals' holding on preemption fully comports with this Court's directive in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 482, 112 L.Ed.2d 474, 483 (1990), that any doubt regarding ERISA's preemptive force must be resolved in favor of the "breadth" and "deliberately expansive" nature of ERISA's objectives. *See Willett*, 953 F.2d at 1341 n.6. The Court of Appeals, specifically considering the Supreme Court's reasoning in *FMC Corp. v. Holliday*, 498 U.S. at 61 (state anti-subrogation statute "directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain"); and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 74 (mandated benefits laws regulate an integral part of the policy relationship "by limiting the type of insurance that an insurer may sell to the policyholder"), correctly concluded that the notice requirements of O.C.G.A. §33-24-44 did not satisfy the McCarran-Ferguson criteria and did not regulate "the business of insurance" for purposes of the ERISA savings clause. There is no basis for further review of the Court of Appeals decision.

B. The Court Of Appeals Correctly Held That Petitioners' Tort Claims Are Clearly Preempted; There Is Nothing To Warrant Further Review.

The Court of Appeals held that Petitioners' effort to boot-strap a tort claim to an alleged violation of O.C.G.A. §33-24-44 is clearly preempted by ERISA. Petitioners claim entitlement to Supreme Court review because, in

their opinion, the Court of Appeals' holding is "illogical and fundamentally erroneous." Petition, p.38. Petitioners continue to ignore the overwhelming body of Supreme Court and Circuit Court decisions establishing the exclusive ERISA remedial scheme and confirming preemption of alternative state tort remedies.

The Court of Appeals aptly observed that this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) establishes that, even where the ERISA savings clause would apply, such savings was necessarily limited to the insurance regulation in question. The Court of Appeals confirmed what this Court has made clear; operation of the savings clause must be limited in accord with congressional intent that ERISA provide the exclusive remedy for benefit disputes. Appendix, p. 31 n.12.

Here, Petitioners repeatedly cite *FMC Corp. v. Holliday*, 498 U.S. at 52, for the proposition that "saved" insurance regulations should trigger state law remedies above and beyond the strictly limited ERISA remedial scheme, 29 U.S.C. §1132. The *FMC Corp. v. Holliday* decision contains no such suggestion. Rather, *FMC Corp. v. Holliday* confirms that, in enacting ERISA, Congress' intent was uniformity in the administration of employee benefit plans; elimination of varying standards and remedies created by differing state laws. *Id.*; *see, Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10, 107 S.Ct. 2211, 96 L.Ed.2d 1, 10 (1987), citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981) ("We have not hesitated to enforce ERISA's preemptive power where

state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements"). It is settled law that there is no state tort remedy available under the exclusive ERISA remedial scheme.[4]

Petitioners' contention that a state-law tort claim should be available to them, defies the purpose of ERISA, long recognized by the Supreme Court, to preserve a "uniform body of benefit law . . . [and] minimize the administrative and financial burden of complying with conflicting directives among the States . . . [which is] fundamentally at odds with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand Corp. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990). Comporting with such precedent, the Court of Appeals correctly observed:

> The instant statute relates directly to the administration of insured benefit plans; to permit the saving clause to foreclose preemption would undermine a core purpose of ERISA – providing uniform standards for administration of benefit plans. Accordingly, we hold that the savings clause does not apply to O.C.G.A. §33-24-44(d), and this case must proceed under ERISA.

Appendix, pp. 31-32 (footnote omitted).

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[4] *See, e.g. Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987) (common law and statutory claims against plan insurer preempted; ERISA preemption extends to insurance coverage disputes); *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 979 (5th Cir. 1991) ("[W]hen beneficiaries seek to recover benefits from a plan covered by ERISA, their exclusive remedy is provided by ERISA").

Petitioners' citation to *Tomczyk v. Blue Cross and Blue Shield United of Wisconsin*, 951 F.2d 771, 776 (7th Cir. 1991) does nothing to support their efforts to avoid this Court's confirmation of ERISA's exclusive remedial scheme. Nothing in *Tomczyk* remotely supports Petitioners' dissatisfaction with the exclusive ERISA remedial scheme. And, the California district court's analysis in *Graves v. Blue Cross of California*, 688 F. Supp. 1405 (N.D. Cal. 1988), concerning an insurance deceptive practice statute, is entirely inapplicable to the instant ERISA benefit eligibility dispute.[5]

The Court of Appeals correctly held that ERISA preemption and the congressional objective of uniformity in ERISA administration, rights and remedies plainly control this O.C.G.A. §33-24-44 claim. The Georgia cancellation statute, as applied to the administration of ERISA health benefits funded by insurance, is preempted by Section 514(a). 29 U.S.C. §1144(a). Petitioners' arguments and the district court's opposite conclusion are contrary to the requirements of the McCarran-Ferguson test, and the weight of authorities here cited. As the Court of Appeals pointedly noted, Petitioners' dispute concerning Mrs. Smith's eligibility for health benefits is governed by the exclusive ERISA remedial scheme; and, Petitioners' ERISA remedy is fully available.

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[5] Moreover, the California district court's rationale is fundamentally at odds with the Ninth Circuit. *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 493-94 (9th Cir. 1988) (ERISA preempts state insurance law claims despite fact that insurance law included private right of action; ERISA's civil enforcement provision is an exclusive remedy).

The Court of Appeals properly remanded this cause to the district court for further proceedings under ERISA's exclusive remedial scheme. This Petition presents no valid basis warranting further review. This Petition should be denied in its entirety.

II. Respondent's Plan Is Governed By ERISA; Exclusionary Regulation 29 C.F.R. §2510.3-1(e) Does Not Apply. This Circuit Court Correctly So Held; There Is No Basis For Further Review.

Applying the ERISA plan criteria of *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) to undisputed record facts, the Medical Plan is an ERISA-governed welfare arrangement.[6]

Petitioners contend that, despite the fact that the Plan meets the ERISA criteria, the Department of Labor's regulation published at 29 C.F.R. §2510.3-1(e) ("Regulation 3-1(e)") excludes the Medical Plan from ERISA's broad

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[6] In *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982), the Eleventh Circuit identified the criteria to establish an ERISA-governed welfare plan:

> By definition . . . a welfare plan requires (1) a "plan, fund, or program" (2) established or maintained (3) by an employer or by an employee organization or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to participants or their beneficiaries.

Petitioners have never even attempted to argue that the Company Medical Plan fails the *Donovan* definition of an ERISA-governed welfare plan.

regulatory scope. The Regulation has never been interpreted or applied in the extraordinary manner requested by Petitioners; the Court of Appeals rejected Petitioners' novel approach. There is no conflict with any Supreme Court or Circuit Court decision; there is nothing to warrant Supreme Court review of Petitioners' novel theory to avoid ERISA regulation.

A. Petitioners' Refusal To Acknowledge The Distinction Between Acts Of The Employer And Acts Of The Plan Is No Basis For Supreme Court Review.

Petitioners insist on mischaracterizing the Company's provisions of health benefits through an ERISA welfare plan as a "sale" between employer and employee. Petitioners' theory is in direct contravention of ERISA's recognition of the Plan as a separate legal entity; and, the legal distinction between acts of the employer and acts of the Plan.[7] *See, e.g., Payonk v. HMW Indus., Inc.*, 883 F.2d 221 (3d Cir. 1989); *Union 2134, UMWA v. Powhatan Fuel*, 828 F.2d 710, 714 (11th Cir. 1987); *Ed Miniat, Inc. v. Globe*

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[7] In claiming ERISA exclusion status under Regulation 3-1(e), Petitioners return to their fiction that the Plan dependent coverage option is a separate and independent plan; and required contributions constitute a sale between employer and employee. The fact is that where the employer creates and maintains a medical plan under the *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) criteria, the ERISA plan status, plan administration ERISA regulation, and preemption, are beneficiaries under plan dependent coverage options. 29 U.S.C. §1002(7, 8). There is no separate "dependent coverage" plan; there is no "sale" of dependent benefits.

Life Ins. Group, Inc., 805 F.2d 732 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987); *Dime Coal Co., Inc. v. Combs*, 796 F.2d 394 (11th Cir. 1986); *Amato v. Western Union Intern., Inc.*, 773 F.2d 1402, 1416-17 (2d Cir. 1985); *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1325 (9th Cir. 1985).

The uncontrovertible fact, established by the legal identity of the entities involved, is that dependent coverage is not offered for "sale" by the Company. Dependent coverage is offered only by and only through the Plan. The contribution prerequisite to maintain such Plan coverage is not a transaction with the Company; it is a transaction with the Plan. The Court of Appeals correctly held that the contribution that was a requirement of the Plan's dependent coverage feature, did not constitute a "sale" under Regulation 3-1(e) and would not remove the Plan from ERISA's regulatory sweep. There is no justification for further review.

Petitioners offer no case law to support their contention, rejected by the Court of Appeals, that a dependent coverage feature may be severed from the rest of an ERISA plan so as to create a Regulation 3-1(e) ERISA exclusion. The Court of Appeals correctly concluded that ERISA's comprehensive scheme is not escaped by including such a "commonplace feature" of group medical plans. Appendix, p.16. Petitioners' disagreement therewith provides no basis for further review.

The Court of Appeals observed that Regulation 3-1(e) could not remove ERISA regulation merely because an insurer-employer funds a health plan through its own

policy of insurance. Dependent coverage requiring participant contribution is no basis to remove a plan from ERISA's regulatory sweep.

> . . . [Petitioners] argue that Jefferson-Pilot sold the dependent coverage to the plaintiff. Although interpretation of this regulation is an issue of first impression, it is clear that §2510.3-1(e) does not apply to the dependent coverage feature contained in the Plan. The plaintiff seeks to sever the dependent coverage feature from the benefits package provided to agents through the Plan. This cannot be done because the dependent coverage was a feature of the Plan, notwithstanding fact that the costs of such coverage had to be contributed by the employee. The plaintiff offers no case law to support the argument that dependent coverage features may be severed from the rest of an ERISA plan, and common sense compels the conclusion that ERISA regulation is not escaped merely by including such a commonplace feature of group plans. The plain language of the regulation indicates that the regulation contemplates a situation where an individual, who incidentally is an employee of an insurance company, purchases on an individual basis – and not as part of an employee welfare benefit plan – a product from that company. Section 2510.3-1(e) does not apply to situations where an employer-insurer has established an employee benefit plan where both the employee and the employer contribute part of the premium of the plan.

Appendix, pp. 15-17 (footnotes omitted).

The Court of Appeals correctly noted that, if Petitioners had purchased medical insurance through insurance policies issued to them, individually, by the Company, such transaction could constitute a "sale" described in Regulation 3-1(e). Such a "sale" is not at issue in this litigation. Election of a dependent coverage option provided in the context of a welfare plan satisfying the *Donovan v. Dillingham* criteria is not a "sale" between employer and employee.[8] The Court of Appeals correctly concluded that DOL Regulation 3-1(e) has no application; that holding, in conflict with no authority, provides no basis for Supreme Court review. This Petition should be summarily denied.

B. Under Petitioners' Novel Theory, Insurance Company Sponsored Plans Would Be Removed From ERISA; The Court Of Appeals Properly Rejected Petitioners' Notion. There Is No Basis For Further Review.

Petitioners seek to avoid ERISA on the basis that Mr. Smith happened to work for an insurance company. The

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[8] Petitioners for the first time advance the novel argument that Jefferson-Pilot made contributions to the Plan "in consideration of [Crawford Smith's] services" and that, by providing his "services" to the Company, Mr. Smith "paid" for the medical plan coverage. Petition, pp. 52-53. The contention is patently absurd. Employers do not "sell" employee benefits; employees do not "buy" them by working. Petitioners' latest attempt to avoid ERISA must fail.

In any event, the argument is raised for the first time in the Petition; neither the district court nor the Eleventh Circuit had this proposition before them. This Court can reject the eleventh-hour argument as waived.

crux of Petitioner's ERISA-exclusionary argument is that employee-paid dependent coverage under an insured plan is exempt from ERISA if the employer-insurer writes the policy funding its employee benefits, and any type of employee contribution is required. Petitioners' argument, taken to its logical conclusion, would void ERISA protections for all participants of the Medical Plan; and for untold numbers of insurance industry employees and their families participating in similar plans. The U.S. insurance industry employees are estimated by the Department of Labor to exceed two million people.

If Petitioners' ERISA exclusionary theory was accepted, two million households could be deprived of ERISA protection merely because benefits are funded by insurer-employers through their own policies and, for some portion of coverage, an employee contribution is required. As the Court of Appeals observed, the use of an insurance policy to fund benefits and the requirement of an employee contribution are both fully authorized by ERISA. The Petitioners' effort to avoid ERISA based on Regulation 3-1(e) was properly rejected.

> Congress expressly contemplated the use of insurance to fund ERISA benefits since it defined covered programs as those funded "through the purchase of insurance or otherwise." 29 U.S.C. §1002(1). Furthermore, ERISA expressly permits insurer-employers to use their own insurance policies to fund ERISA governed benefits by exempting such transactions from the statute's prohibited transaction provisions. 29 U.S.C. §1108(b)(5). Thus, Jefferson-Pilot's issuance of its own policy to fund the Plan does not defeat ERISA coverage. The Secretary of

> Labor has also expressly acknowledged ERISA jurisdiction over plans that deduct employee contributions. 29 C.F.R. §2510.3-102.

Appendix, p. 17 n.4.

Under the Petitioners' theory, ERISA protections would be denied to insurance industry employees and their families. There is no rationale or justification for such an arbitrary and far reaching result. The Court of Appeals held, properly, that Regulation 3-1(e) has no application to these facts; ERISA coverage is not abrogated based on the industry of the employer. This Petition contains no facts or law to warrant further review of this issue.

CONCLUSION

This lawsuit is grounded on alleged wrongful denial of health benefits provided, sponsored and partially funded by Crawford Smith's employer, through a group Plan. The Court of Appeals correctly held that the Plan and the benefit entitlement dispute which are the crux of this claim, are governed by ERISA.

The Court of Appeals correctly refused Petitioners' contention that the Georgia insurance cancellation statute, which governs the administrative steps necessary for cancellation of an insurance policy, is saved from ERISA preemption through Section 514(a), as applied to the administration of ERISA governed health benefits funded through insurance. The Court of Appeals correctly and carefully applied the McCarran-Ferguson criteria to conclude that the cancellation statute did not qualify as a

state law regulating the business of insurance; and therefore was not saved from preemption as a state law regulating insurance. The Court of Appeals further correctly held that a litigant may not boot-strap a tort claim to an O.C.G.A. §33-24-44 claim to avoid ERISA's exclusive remedial scheme.

And, the Court of Appeals correctly rejected Petitioners' misapplication of 29 C.F.R. §2510.3-1(e), and correctly refused to eliminate ERISA regulation as applied to insurer sponsored and funded plans.

This case simply does not present any issue which is appropriate for consideration by this Court on certiorari. The rulings below involve narrow legal questions which were fully addressed by the Court of Appeals, involve no significant conflict of circuit court decisions, and were resolved by the Eleventh Circuit in full accord with the body of Supreme Court and circuit court precedent. The Court of Appeals fully identified and confirmed Petitioners' ERISA remedy. The Court of Appeals properly remanded this cause for trial on the merits under ERISA's exclusive remedial scheme. Petitioners' continued dissatisfaction with that federal remedy provides absolutely no basis for Supreme Court review. This Petition for Certiorari should be denied.

Respectfully submitted,

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